Advance-care planning implementation through the nursing process

Every human being has an inevitable certainty about life: its finitude. Modern societies view life as physical and mental fullness while having difficulty accepting that disease and suffering are integral parts of life, and death is the inevitable end of it. But much as we try to avoid, deny or hide it, we all wish to face it with as much dignity as possible (Fernández-Sola et al., 2017).

In the past, death was viewed as a natural event, accepted by society. Generally, it occurred within the family, with the patient surrounded by the care and affection of their loved ones. Today, death is a technified event that is increasingly occurring in hospitals, where the patient is subjected to numerous diagnostic and therapeutic procedures (Cox, 2018). Between 50-80% of the deaths in Europe take place in medical facilities (Gomes et al., 2012). In recent decades, biotechnological advances have led to substantial improvements in the biological attention to the human being. However, the psychological, social and spiritual dimensions that, along with the biological, make up the individual, have been disregarded (Azhar & Bruera, 2018).

Talking about the meaning of life and how we would like to live it until the end is not an easy task. Nor is it easy to preserve the right of autonomy and self-determination by patients who are unable to exercise that right or are at the end of their lives (Nouvet et al., 2016). If we wish to provide health care that protects patient values and preferences, and help them die in peace, it is necessary to find a way to systematically implement the Advance-Care Planning (ACP) process (McGlade et al., 2017; Ke et al., 2015).

The purpose of this article is to review the literature on the importance of ACP and present a theoretical model of its implementation through the Nursing Process (NP). To achieve this, the key Functional Health Patterns in the ACP approach, nursing diagnoses

(NANDA), nursing outcomes (NOC) and nursing interventions (NIC) related to ACP will be identified.

Advance-Care Planning

ACP is a continuous, dynamic and voluntary process of deliberation and communication between a capable person, their family, representative, friends and the health professionals involved in their care. ACP discussions cover values and preferences that patients wish to be taken into account regarding their end of life care.

ACP was developed in the United States of America (USA) in 1994. An American bioethicist group at the Hasting Center warned that completing a document such as Advanced Directives (AD), Living Will, or Power of Attorney, was no guarantee that patient wishes would be adhered to if they were unable to exercise their rights. The ACP process brought patients into a decision-making role about their health and end of life care (Flo et al., 2016).

The goal of this process is to help people prepare for death by expressing their preferences regarding the health care they wish to receive at the end of their life.

ACP provides patients, their families and relatives a period of time to accept the finiteness of life and face death. All this is achieved through conversations which clarify the values and preferences of the patient and establish a decision-making plan consistent with their wishes. In this way, patients gain more control over their illness and life. They obtain health care in congruence with their particular ways of life. They attain, along with their families, a high degree of satisfaction about the care received. The main objective of the ACP is to facilitate deliberation and communication in order to get the patient ready for death.

The current situation

ACP is a widely known process in the USA; some institutions, such as the National Institute of Aging, Medicare or Centers for Disease Control and Prevention recommend it. However, it is still not systematically implemented within the daily health care professional practice

(Agarwal & Epstein, 2018). According to the Royal College of Physicians the data available from the records of ACP discussions are well below the desirable level: only between 10-20% of the USA population has registered an ACP process. Other programs or resources have been developed to achieve a similar objective, such as *Five Wishes*, *Physician Orders for Life Sustaining Treatment, Let Me Talk, Let Me Decide*, *Speak Up*, among others (Flo et al., 2016).

The United Kingdom, Ireland, Sweden, Norway, the Netherlands, Belgium, Germany, Portugal, Australia, New Zealand and Canada are among the countries that have been advancing this process. Studies in these countries (McGlade et al, 2017; Bollig et al., 2016) have demonstrated the benefits of implementing ACP. Studies have been performed in hospital settings and in the general healthcare community. They have demonstrated that ACP is a process which improves the quality of health care at the end of life, while respecting patient values and preferences, and protecting their rights more effectively than AD, Living Will, or Power of Attorney (Brinkman-Stoppelenburg et al., 2014).

Nurses in the Advance-Care Planning process

Healthcare workers are responsible for initiating the ACP process (Bollig et al., 2016). Physicians and nurses are the groups most involved in the decision-making process of patients, and the most appropiate to lead this process. Numerous studies (Agarwal & Epstein, 2018; McGlade et al., 2017; Rabow et al., 2019; Ke et al., 2015) show the suitability of the nursing profession to direct and promote ACP, for several reasons: Nurses constitute the largest portion of the healthcare professionals and are omnipresent in the main healthcare institutions (hospitals and nursing homes) where a high percentage of the patients live or die. Nurses are also in the strategic position of being close to the patients 24 hours a day, in constant communication with them and their families, and are members of the attending medical teams (Ke et al., 2015; Izumi, 2017). Finally, nursing ethics, as stated in the Code of

Ethics for Nurses (American Nurses Association), focuses on the needs of people and recognizes the importance of experiences and personal relationships in the whole health-disease process, including the resolution of ethical dilemmas at the end of life.

The Nursing Process

The NP, like ACP, is a continuous and dynamic process that adapts to the constant changes in patient health experience.

The professionalization of nursing creates the need to transform the body of knowledge of the discipline into scientific knowledge. NP was created to that end: a rational and systematic method of planning and apportioning of nursing services. The purpose of this process is to identify the health status of a person, family or group, identify actual or potential health problems, establish plans that meet the identified needs and apply specific and individualized nursing interventions that meet those needs. The implementation of NP allows nursing professionals to provide patient care in all its dimensions (Azevedo et al., 2019).

Advance-care planning implementation through the nursing process

Method

A review of the scientific literature was conducted with the objective of investigating whether ACP had been related or linked to the NP, the Functional Health Patterns or with NNN Taxonomy. The following search equations were used: ("Nursing Methodology Research"[Mesh] AND "Advance Care Planning"[Mesh]) and ("Nursing Process"[Mesh]) AND "Nursing Diagnosis"[Mesh]). After the search and perusing of the references, no studies were found that related the previously mentioned elements.

Taking into account the above, the possibilities of implementing the ACP process through the NP were studied at a theoretical level, seeking to establish links and interrelations between the two. To carry out this work, the following sources were used: Manual of Nursing Diagnosis (Gordon, 2016); Nursing Diagnoses. Definitions and Classification 2012-2014

(Herdman & Kamitsuru, 2014); Nursing Outcomes Classification (NOC) (Moorhead et al., 2013); Nursing Interventions Classification (NIC) (Bulechek et al., 2013); and NOC and NIC Linkages to NANDA-I and Clinical Conditions: Supporting Critical Thinking and Quality Care (Johnson et al., 2012).

The analysis of the literature found was developed in 4 phases that are presented below:

1. **Identification of the key concepts of the ACP.**

To identify the key concepts of the ACP, the literature review and the following definition agreed by a group of experts in 2015, were taken into account: "Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness" (Sudore et al., 2017, p. 824). After a thorough study and an assessment of what this process means, the key concepts were determined: *decision making, knowledge, life cycle, end of life, coping or problem solving and autonomy*. These key concepts will be fundamental to the identification of Functional Health Patterns, nursing diagnosis (NANDA), nursing intervention (NIC), nursing outcomes (NOC) and their correlations (NNN linkages), related to the ACP process.

2. **Analysis of the Functional Health Patterns through which an ACP can begin.**

First, all data were identified and evaluated in each pattern analyzed. Secondly, patterns were identified from which information related to the key concepts could be collected.

3. **Identify the Nursing Diagnosis related to the ACP.**

Those nursing diagnosis in which any of the key concepts were present in their defining characteristics or related factors, were considered.

4. **Identify the Nursing Outcomes and the Nursing Intervention related to the ACP.**

Once the nursing diagnosis were selected, we worked with the following source: "NOC and NIC Linkages to NANDA-I and Clinical Conditions: Supporting Critical Thinking and Quality Care" (Johnson et al., 2012). Based on the nursing outcomes and nursing intervention proposed for each selected nursing diagnosis, those related to the ACP process were identified. In the selection process, it was considered that some of the key concepts appeared in the nursing outcomes indicators and in the nursing intervention activities.

Results

In accordance with the methodological process used, the following interrelations between the NP and the ACP were identified (Table 1) according to the key concepts: *decision making, knowledge, life cycle, end of life, coping or problem solving and autonomy*.

ACP can be applied with the information obtained from the assessment of 5 of the 11 Functional Health Patterns, which provide valuable information for decision making. These are as follows: the *Cognitive Perceptual Pattern* is useful because through it situations can be identified related to the ability to make decisions and the degree of patient knowledge regarding their illnesses; the *Self-Perception-Self-Concept Pattern*, because it identifies situations of anxiety about death and assesses whether human dignity is being violated; the *Role-Relationship Pattern*, because it emphasizes the family and social relationships of the person, so important in the ACP process; the *Coping-Stress Tolerance Pattern*, because it identifies the coping strategies of the person in the face of stressors and death; finally, the *Value-Belief Pattern*, because through it the values and beliefs that are really important for the person are collected. Through these patterns, circumstances or health problems can be

identified that can be labeled by any of the 16 nursing diagnoses selected. On the other hand, 30 nursing outcomes and nursing intervention, related to the ACP process, have been identified. All of the above make it possible that through the NP, the ACP can be implemented.

Case Study

As an example to demonstrate the use of NP as a method for addressing the ACP, a fictitious case is presented below.

Peter is 82 years old and diagnosed with a terminal illness: Phase IV malignant melanoma with pulmonary metastases. The previous year, his son had to move from the city for work reasons, which motivated Peter's decision to be admitted to a long-stay hospital.

Every morning, a nurse enters Peter's room to assess his status and take his vital signs. While she is taking his blood pressure, she asks him if he is worried about something. Peter tells her that his son has called him to say he is returning to the city with his three children (Peter's grandchildren). He has proposed that he return home to take care of Peter until the end. Peter does not know what to do; he would love to spend the last months of life watching his grandchildren play and being close to his son, but he is afraid. Peter wonders what he will do when he has a lot of pain or has a hard time breathing and is unable to call for a nurse. He says that in the hospital he is very well taken care of and fears that he may not receive the same care at home.

NP Clinical Case

The nurse will warn that, within the *Value-Belief Pattern*, Peter has a need that is not being met and will be able to make the following diagnosis: *Moral Distress* related to *End-of-life decisión* as manifested by *Expressed anguish (fear) over difficulty in acting on one´s moral choice.*

In order to help Peter, in the planning phase, the nurse could set the NOC as *Personal Autonomy and Dignified Life Closure* because he would like to go home to watch his grandchildren grow and die surrounded by his loved ones, but he is afraid to make this decision. In the Implementation, the main NIC that could be performed would be *Decision-Making Support* and its activities: *help the patient identify the advantages and disadvantages of each alternative; provide information requested by the patient; help patient explain a decision to others, as needed; serve as a liaison between the patient and additional healthcare providers.*

In the above example, it can be seen how an ACP process can be initiated through the NP. The nurse opens ACP discussions with the patient to help him reflect, clarify his preferences, and understand what health system resources can be had at home. The nurse invites him to reflect all this with his son and the medical team so that he can make decisions consistent with his vital project, trying to respond to the suffering currently endured by the patient (Table 2).

Nurse leadership in the Advance-Care Planning

The present study represents a breakthrough in nursing science and a benefit for society. With respect to nursing, this is because the possibility of implementing the ACP through the NP makes it possible for nursing professionals to lead a process of vital importance for the human well-being, and systematically apply it in their daily practice. With respect to societal benefits, the study asserts that all people have the right to be taken into account and have their values and preferences respected, and all need to prepare reach life's end on their own terms. The right of self-determination considers that all adult human beings in full use of their mental faculties have the right to decide what will be done with their own bodies. This right is supported and protected by the Nuremberg Code, the Declaration of Helsinki, and the Oviedo Convention, among others. This right must also be safeguarded

when the person is unable to exercise it, as indicated in the fifth article of the Universal Declaration of Bioethics and Human Rights of UNESCO.

In 2009, the Council of Europe recommended that the European Union member countries use AD as a valid means to protect the right of self-determination. The studies that have focused on AD have confirmed that this document has many advantages, but also some limitations (Hinders, 2012). Therefore, it is necessary to consider AD not as an end in itself but as a valid instrument within the ACP to protect the right of people to decide on their health and life. Along these lines, many studies (Brinkman-Stoppelenburg et al., 2014; Detering et al., 2010) have already demonstrated the benefits of ACP and have recognized the process as a valid means to protect the rights of persons who are in situations that make it impossible for them to make decisions about their own health. Consequently, as some studies show, it is necessary to find a way to standardize ACP to achieve its implementation in the healthcare practice (Agarwal & Epstein, 2018; Izumi, 2017). There are other programs whose purpose is to structure and implement the ACP (Agarwal & Epstein, 2018). These tools are not useful in all possible scenarios as they involve an economic cost, and entail specific training by health personnel.

The main result of this work demonstrates that it is possible to develop the ACP through the NP. As it is shown in Table 1, and to the best of our knowledge, this is the first time that connections between ACP, Functional Health Patterns, nursing diagnoses (NANDA), nursing interventions (NIC), and nursing outcomes (NOC) have been stablished. This work stablishes the possible links so that the ACP can be implemented through the NP.

When nurses, during the patient assessment, identify any of the sixteen selected diagnoses (Table 1): Death Anxiety (000147), decisional conflict (00083), Spiritual distress (00066), etc. they will be able to recognize if the patient is suitable to implement the Advance Care Planning. In that case, nurses would be able to lead the ACP and implement it through

the Nursing Process. The implementation of some of the nursing interventions (NIC) showed at Table 1, will make possible the achievement of the nursing outcomes (NOC) that appear in the same table. The final result would be the Advance Care Planning implementation through the Nursing Process, as it is shown in the example (Table 2).

This finding allows the ACP to be implemented in a simple way in the nursing care practice in all countries and possible scenarios, taking into account that NP is an internationally known process and that nursing professionals have been trained in this methodology (Herdman & Kamitsuru, 2014). It can be added to all of the above that assistance centers already have computer tools through which to register the NP, and therefore it would not be necessary to acquire any specific program to be able to start, register, consult and periodically evaluate the ACP process.

This result points to nurses becoming the leading professionals responsible for ACP. In that sense, the study by Izumi (2017) indicates the need to define the roles of nurses, since the lack of clarity in this regard raises a barrier to the implementation of the ACP. All members of a health team must be aware of the importance of the ACP and must take responsibility for this process; but to ensure that ACP is present in the daily healthcare practice, it is necessary that a specific establishment assumes leadership.

Nursing professionals are prepared to take on this challenge, and their role in the ACP is widely recognized (Izumi, 2017). The review by Ke et al. (2015) concluded that nurses play a key and decisive role in the advice, information, education, communication, facilitation and advocacy aspects of the ACP. On the other hand, the Hospice an Palliative Nurses Asociation (2018) declared that nurses could lead the ACP because they know the patients, their family dynamics, have the training to describe clinical situations, and they are responsible for educating the patients, and protecting their rights.

The main barriers that nursing professionals could encounter would be the following. First, there is the high care burden that sometimes prevents attending to the psychological and spiritual dimension of patients. The scarcity of time becomes a limitation to initiate or maintain ACP discussions. This situation could be remedied by recognizing the leadership and management of the ACP within the nursing functions. A second barrier is the lack of specific training in the ACP process. Bearing in mind that nursing professionals already have a background in psychology, sociology, anthropology, philosophy, and ethics from their university studies, they are trained in communication skills and abilities, and have acquired a great capacity for observation that allows them a better understanding of the human health experience. Therefore, it would be sufficient for them to receive specific training in the ACP process as a continuing education during their professional careers or during their nursing studies.

The main limitation of this work is that it is a theoretical model. A future line of research would be to implement it in healthcare centers.

Conclusion

The ACP process can be developed through the NP. Nurses can take advantage of the information obtained, in the assessment phase, especially of the Functional Health Patterns: Cognitive Perceptual Pattern, Self-Perception-Self-Concept Pattern, Role-Relationship Pattern, Coping-Stress Tolerance Pattern and Value-Belief Pattern, in order to discover health situations identifiable with any of the 16 nursing diagnoses selected as useful to address and initiate the ACP process. After the diagnosis phase, the care plan can be delineated, establishing the desired results and the necessary interventions to achieve them. Thirty nursing outcomes and 30 nursing interventions linked to the 16 nursing diagnosis have been selected, from which it is possible to develop, in the execution phase, an ACP process.

Implications for nursing practice

This study represents a breakthrough in nursing science because it explains how to implement the ACP through the NP. It is the responsibility of the nursing professional to protect patient rights, preserve their autonomy and help them die in peace. Through the NP, it is possible to identify situations in which it is necessary to start an ACP and to plan activities that will carry it out. This makes it possible for nurses to lead a process of vital importance to patient and to apply it systematically in their daily practice.

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Table 1. Nursing Diagnosis-Nursing Intervention-Nursing Outcomes interrelations linked to the Advance Care Planning Process. Source: Herdman & Kamitsuru, 2014; Moorhead, 2013; Bulechek, 2013.

Functional Health Patterns	**(NANDA) Nursing Diagnosis**	**(NOC) Nursing Outcomes**	**(NIC) Nursing Interventions**
Cognitive Perceptual Pattern	Decisional Conflict (00083)	Personal Autonomy (1614)	Decision-Making Support (5250) Health System Guidance (7400)
		Information Processing (0907)	Decision-Making Support (5250) Health Literacy Enhancement (5515)
		Participaction in Health Care Decisions (1606)	Decision-Making Support (5250) Health System Guidance (7400) Values Clarification (5480)
		Decision-Making (0906)	Decision-Making Support (5250) Values Clarification (5480)
	Readiness for Enhanced Decision-Making (00184)	Personal Autonomy (1614)	Decision-Making Support (5250) Self-Efficacy Enhancement (5395)

		Adherence Behavior (1600)	Health Education (5510)
		Health Beliefs (1700)	Decision-Making Support (5250)
		Decision-Making (0906)	Values Clarification (5480)
	Deficient Knowledge (00126)	Knowledge: Disease Process (1803)	Teaching: Disease Process (5602)
		Knowledge: Health Resources (1806)	Health Education (5510)
			Health System Guidance (7400)
	Readiness for Enhanced Knowledge (00161)	Knowledge: Disease Process (1803)	Commendation (4364)
			Self-Responsability Facilitation (4480)
			Learning Facilitation (5520)
			Self-Efficacy Enhancement (5395)
		Knowledge: Health Resources (1806)	Health Education (5510)
			Health System Guidance (7400)
Self-Perception-Self-Concept Pattern	Death Ansiety (000147)	Acceptance: Health Status (1300)	Copy Enhancement (5230)
			Anxiety Reduction (5820)
		Hope (1201)	Spiritual Support (5420)
			Anticipatory Guidance (5210)

		Comfortable Death (2007)	Dying Care (5260)
			Anxiety Reduction (5820)
		Dignified Life Closure (1307)	Decision-Making Support (5250)
		Spiritual Health (2001)	Spiritual Support (5420)
			Spiritual Growth Facilitation (5426)
			Religious Ritual Enhancement (5424)
	Risk for Compromised Human Dignity (00174)	Dignified Life Closure (1307)	Decision-Making Support (5250)
		Client Satisfaction: Protection of Rights (3008)	Patient Rights Protection (7460)
		Personal Autonomy (1614)	
		Participaction in Health Care Decisions (1606)	
		Client Satisfaction: Communication (3002)	
Role-Relationship Pattern	Dysfunctional Family Processes (00063)	Family Coping (2600)	Family Therapy (7150)
			Copy Enhancement (5230)
		Family Social Climate (2601)	Family Integrity Promotion (7100)
		Family Functioning (2602)	
		Family Integrity (2603)	

		Family Resiliency (2608)	Resiliency Promotion (8340) Family Process Maintenance (7130)
	Interrupted Family Processes (00060)	Family Coping (2600)	Copy Enhancement (5230) Family Process Maintenance (7130)
		Family Social Climate (2601) Family Functioning (2602) Family Normalization (2604) Family Resiliency (2608)	Family Integrity Promotion (7100) Family Process Maintenance (7130) Resiliency Promotion (8340) Family Process Maintenance (7130)
	Readiness for Enhanced Family Processes (00159)	Family Social Climate (2601) Family Functioning (2602) Family Integrity (2603) Family Resiliency (2608)	Family Integrity Promotion (7100) Resiliency Promotion (8340) Family Process Maintenance (7130)
Coping-Stress Tolerance	Ineffective Coping (00069)	Coping (1302)	Decision-Making Support (5250) Copy Enhancement (5230)

Pattern		Knowledge: Health Resources (1806)	Counseling (5240)
			Health System Guidance (7400)
		Comfortable Death (2007)	Dying Care (5260)
			Anxiety Reduction (5820)
		Psychosocial Adjustment: Life Change (1305)	Copy Enhancement (5230)
			Anticipatory Guidance (5210)
		Decision-Making (0906)	Decision-Making Support (5250)
			Anticipatory Guidance (5210)
	Compromised Family Coping (00074)	Family Coping (2600)	Family Involvement Promotion (7110)
			Copy Enhancement (5230)
			Family Therapy (7150)
		Family Normalization (2604)	Family Support (7140)
			Family Involvement Promotion (7110)
			Family Process Maintenance (7130)
		Caregiver-Patient Relationship (2204)	Caregiver Support (7040)
		Caregiver Emotional Health (2506)	

	Caregiver Role Endurance (2210)	
Grieving (00136)	Coping (1302)	Copy Enhancement (5230)
		Grief Work Facilitation (5290)
	Psychosocial Adjustment: Life Change (1305)	Copy Enhancement (5230)
		Anticipatory Guidance (5210)
	Grief Resolution (1304)	Grief Work Facilitation (5290)
Ineffective Activity Planning (00199)	Health Beliefs: Perceived Ability to Perform (1701)	Learning Facilitation (5520)
		Self-Efficacy Enhancement (5395)
	Motivation (1209)	Self-Responsability Facilitation (4480)
		Self-Efficacy Enhancement (5395)
	Decision-Making (0906)	Decision-Making Support (5250)
		Mutual Goal Setting (4410)
Readiness for Enhanced Power (00187)	Personal Autonomy (1614)	Decision-Making Support (5250)
		Values Clarification (5480)
		Self-Efficacy Enhancement (5395)
	Participaction in Health Care Decisions (1606)	Decision-Making Support (5250)

			Mutual Goal Setting (4410)
			Self-Responsability Facilitation (4480)
Value-Belief	Moral Distress (000175)	Personal Autonomy (1614)	Decision-Making Support (5250)
Pattern		Dignified Life Closure (1307)	Conflict Mediation (5020)
			Patient Rights Protection (7460)
	Spiritual Distress (00066)	Quality of Life (2000)	Values Clarification (5480)
		Dignified Life Closure (1307)	Decision-Making Support (5250)
			Copy Enhancement (5230)

Table 2. Example implementation of ACP process through the NP. Source: Herdman & Kamitsuru, 2014; Moorhead, 2013; Bulechek, 2013.

NANDA: Moral Distress (000175)		
Definition*: Response to the inability to carry out one´s chosen ethical/moral decision/action.*		
Defining Characteristics: *Expresses anguish (e.g., powerlessness, guilt, frustration, anxiety, self-doubt, fear) over difficulty acting on one´s moral choice.*	**Related Factors:** *Conflict among decision-makers* *Conflicting information guiding ethical decision-making* *Conflicting information guiding moral decision-making* *Cultural conflicts* *End-of-life decision* *Loss of autonomy* *Physical distance of decision-maker* *Time constraints for decision-making* *Treatment decisions*	
Nursing Outcomes (NOC)	**Mayor Interventions (NIC)**	**Suggested Interventions (NIC)**
Personal Autonomy *Personal actions of a competent individual to*	**Decision-Making Support** *Providing information and support for a patient who is*	Emotional Support Spiritual Support

exercise governance in life decision. **Dignified Life Closure** *Personal actions to maintain control when approaching end of life.*	*making a decision regarding health care.* **Conflict Mediation** *Facilitation of constructive dialogue between opposing parties with a goal of resolving disputes in a mutually acceptable manner.* **Patient Rights Protection**	Values Clarification Dying Care Anticipatory Guidance Truth Telling Spiritual Growth Facilitation Grief Work Facilitation